July 14, 2003

MDR Tracking #: M2-03-1378-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Orthopedic Surgery. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___is a 33-year-old male who injured his lower back almost two years ago on ___ while carrying some heavy trays. Over the past two years he has had extensive conservative treatment, and has received no relief from it. He is still not able to return to work some two years later. ___ has received physical therapy and medication including anti-inflammatory drugs and muscle relaxants. He has had a series of epidural steroid injections and has done exercise, but nothing has actually relieved his pain. He primarily has axial pain and does not have evidence of nerve root compression in his imaging studies. On December 9, 2002 he had a provocative discogram done by ___. He had concordant pain at L3/4 but he had only mild pain at L4/5. However, at L4/5 there was a significant annular tear and the disc could not be pressurized.

This patient does not desire to consider surgical treatment, which would be interbody fusion, in his back. His treating physician, ___, has requested permission to do an IDET procedure at the L3/4 and L4/5 level, but the carrier has not approved this procedure.

REQUESTED SERVICE

An IDET procedure is requested for this patient.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

The ___ reviewer finds that the IDET procedure on this patient is indicated. This patient has gone nearly two years with functionally limiting low back pain and has not been able to return to work. He has a basically normal neurological examination and a negative straight leg raising test in the sitting position, according to the designated doctor.

The discogram has reported concordant pain at one level and the other level could not be pressurized, so the reviewer does not find that the absence of concordant pain at L4/5 would be an indication not to do an IDET procedure at that level. The MRI has demonstrated non-compressive disc degeneration, and the reviewer believes that this patient falls into the category that is described by Saal and Saal in their article in *Spine*, February 2000.

The reviewer finds that an IDET procedure is indicated for this patient. This procedure would certainly be a simpler alternative to an interbody fusion at two levels on this young man.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, dba ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).